Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NALINI NAIK, DO
3100 TIMMONS LANE, STE 250
HOUSTON, TX 77027

Respondent Name

HARRIS COUNTY

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-12-0739-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor has not provided a position statement with MFDR submission.

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In the instant case, the provider resubmitted different dollar amounts two separate times following the original bill submission… The medical documentation submitted does not support the change in the unit amounts."

Response Submitted by: Thornton, Biechlin, Segrato, Reynolds & Guerra, L.C., Attorneys At Law, 912 South Capital of Texas Highway, Suite 300, Austin, Texas 78745-5242

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 03, 2011	99456-W5-WP	$300.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated April 07, 2011
   - No exception codes are on this explanation of benefits.

- Comments: W9-VEND

Explanation of benefits dated June 20, 2011

- W3 – Additional payment made on appeal/reconsideration.
- W1A – Workers Compensation State Fee Schedule Adjustment*Reimbursement per Rule 134.204/134.204. Prior to March 1, 2008, Rule 134.202.*
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- Comments: RECONSIDERATION 942026 ALLOWING THE FOLLOWING SERVICES ON APPEAL. REIMBURSING FOR THE NON-MUSCULAR BODY AREA (HEAD)

Explanation of benefits dated July 05, 2011

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. *Duplicate Appeal. An appeal of the original audit was previously performed for these services.*
- Comments: RECONSIDERATION 944971 DUPLICATE APPEAL

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The provider billed CPT code 99456-W5-WP for a DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the documentation supports that MMI was assigned and an IR was determined. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Per Texas Administrative Code §134.204(j)(4)(C)(i)(I), lumbar, cervical, thoracic and pelvis are part of one body area, the spine. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for the IR using Diagnosis Related Estimates (DRE) Category I method on the cervical and thoracic (spinal region) is $150.00. Per 28 Texas Administrative Code §134.204(j)(4)(D)(iv) & (v) the MAR for the IR using the AMA Guides to the Evaluation of Permanent Impairment, 4th Edition on the residual headaches and the chest contusion is $150.00 each. Documentation supports the musculoskeletal rating of the shoulders, right elbow and right hand/fingers (upper extremities and hands) per the Range of Motion (ROM) IR method per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a) with a MAR of $300.00. The combined MAR for all of the MMI/IR services rendered would be $950.00 for all impairment ratings supported by documentation.
2. The MAR amount of $950.00 for the CPT code 99456-W5-WP has already been reimbursed. Therefore, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 13, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.